## San Francisco Health Care Accountability Ordinance
### Minimum Standards – Effective January 1, 2017

<table>
<thead>
<tr>
<th>Benefit Requirement</th>
<th>Minimum Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Premium Contribution</td>
<td>Employer pays 100%</td>
</tr>
</tbody>
</table>
| 2. Annual OOP Maximum                       | • In-Network: $6,850  
• Out-of-Network: Not specified  
OOP Maximum must include all types of cost-sharing (deductible, copays, coinsurance, etc.); and  
Employer may offer a plan with a higher OOP maximum only if they combine it with a fully employer-funded HSA or HRA for the amount exceeding $6,850. |
| 3. Regular (Medical Services) Deductible    | • In-Network: $2,000  
• Out-of-Network: Not specified  
The employer must cover 100% of the medical deductible and may do so with either a fully employer-funded HSA or HRA. The HSA or HRA must provide first dollar coverage. |
| 4. Prescription Drug Deductible             | • In-Network: $250  
• Out-of-Network: Not specified                                                                                                                     |
| 5. Prescription Drug Coverage               | Plan must provide drug coverage, including coverage of brand-name drugs.                                                                                                                                      |
| 6. Coinsurance Percentages                  | • In-Network: 70%/30%  
• Out-of-Network: 50%/50%                                                                                                                              |
| 7. Copayment for Primary Care Provider Visits | • In-Network: $45 per visit.  
• Out-of-Network: Not specified                                                                                                                              |
| 8. Ambulatory Patient Services (Outpatient Care)* | • When coinsurance is applied See Benefit Requirement #6  
• When copayments are applied for these services:  
• Primary Care Provider: See Benefit Requirement #7  
• Specialty visits: Not specified                                                                                                                              |
<table>
<thead>
<tr>
<th>Benefit Requirement</th>
<th>Minimum Standards</th>
</tr>
</thead>
</table>
| 9. Preventive & Wellness Services                       | • In-Network: Provided at no cost, per ACA rules.  
• Out-of-Network: Subject to the plan’s out-of-network fee requirements.                                                                                           |
|                                                         | **Covered California provides a list** of covered preventive services. These services are standardized by **federal ACA rules** at no charge to the member.               |
| 10. Pre/Post-Natal Care                                 | • In-Network: Scheduled prenatal exams and first postpartum follow-up consult is covered without charge, per ACA rules.  
• Out-of-Network: Subject to the plan’s out-of-network fee requirements.                                                                                      |
|                                                         | **Covered California provides a list** of covered pre/post-natal care services. These services are standardized by **federal ACA rules** at no charge to the member.               |
| 11. Hospitalization*                                    | • When coinsurance is applied See Benefit Requirement #6  
• When copayments are applied for these services: Not specified                                                                                               |
| 12. Mental Health & Substance Use Disorder Services, including Behavioral Health* | • When coinsurance is applied See Benefit Requirement #6  
• When copayments are applied for these services: Not specified                                                                                               |
| 13. Rehabilitative & Habilitative Services*             | • When coinsurance is applied See Benefit Requirement #6  
• When copayments are applied for these services: Not specified                                                                                               |
| 14. Laboratory Services*                                | • When coinsurance is applied See Benefit Requirement #6  
• When copayments are applied for these services: Not specified                                                                                               |
| 15. Emergency Room Services & Ambulance*                | Limited to treatment of medical emergencies. The in-network deductible and coinsurance also apply to emergency services received from an out-of-network provider.                     |
| 16. Other Services*                                     | The full set of covered benefits is based on the ACA list of Essential Health Benefits in conjunction with the [Covered California EHB Benchmark plan](#). |

* Coverage of these services are standardized under ACA rules. Cost-sharing for these services are to conform to the requirements above.